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REPORT

TO THE

COMMITTEE ON THE BUDGET

FROM THE

COMMITTEE ON VETERANS' AFFAIRS

SUBMITTED PURSUANT TO SECTION 301 OF THE CONGRESSIONAL BUDGET ACT OF 1974

ON THE

BUDGET PROPOSED FOR FISCAL YEAR 2002

MARCH 13, 2001.—Printed for the use of the Committee on Veterans' Affairs of the House of Representatives

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LETTER OF TRANSMITTAL

HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC, March 12, 2001.

Hon. JIM NUSSLE,
Chairman, Committee on the Budget,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: Enclosed with this letter is the Veterans' Affairs Committee's report on the fiscal year 2002 budget for veterans' benefits and services.

The Administration's proposed increase of $1 billion for veterans discretionary spending is a good starting point for consideration of funding for veterans' programs. The Committee believes that the VA has been impaired in its ability to improve customer service and efficiency because it has had little choice but to shift resources from one program crisis to another as the result of underfunding and insufficient staff. This self-defeating cycle must stop if veterans are to receive in a reasonable time the benefits Congress intended for them, and if the modernization of veterans health care is to be completed.

The Committee is concerned that the level of funding requested by the Administration may leave the VA with insufficient resources to achieve the changes the President has said he wants to implement. More seriously, the existing problems of long waits for health care services and benefit decisions would be exacerbated. The decline in health care services for our oldest and most chronically ill veterans is well documented and should be addressed as soon as possible. Inflation alone would require the addition of more than a billion dollars to the VA health care budget. If inflation in health care should prove to be higher than predicted, the effect on the veterans budget would be even greater. While there is room to expect some management savings, the budget for veterans should be backed by sufficient appropriations, and not depend on uncertain contingencies or dubious devices to be fully adequate.

Therefore, the Committee proposes a realistic increase in spending of $2.1 billion above the 2001 level of veterans funding. The increase would include an increase of $1.5 billion for VA health care and an additional $350 million to repair rundown, substandard and unsafe hospitals. The recent earthquake in the Pacific Northwest seriously damaged two patient care buildings at the American Lake VA Medical Center that had previously been reported as having seismic deficiencies. Fortunately, there was no serious injury or loss of life.

Further, the Committee proposes a necessary increase of $250 million to fund operations of VA's benefits delivery and cemetery systems for fiscal year 2002. The backlog of benefit claims has grown to a completely unacceptable level of more than 459,000 cases. While long-term improvements through information technology and business process reengineering are essential to improving claims processing and must be pursued aggressively, the benefits system is also experiencing serious human capital shortages. Much of its workforce is approaching retirement eligibility at the same time claims rates are at a record high. Therefore, the Committee further proposes an essential increase of $49.8 million in operating funds for VA regional offices to hire and train 830 FTEE in additional staff for claims processing and support.

We also strongly recommend making the Montgomery GI Bill a better tool for both military recruitment and veterans transition purposes by raising the monthly benefit from $650 to $800. Our servicemembers deserve an adequate level of support if they wish to further their educations. We believe that an incremental path to a $1,100 monthly benefit is a worthwhile goal, even though that level in buying power would remain well below what the government provided to World War II veterans. We estimate that funding for this increase and for the Veterans Opportunities Act of 2001 will require $300 million in fiscal year 2002.

We believe it is imperative that the House add the funds identified in this letter and its accompanying background and recommendations on the veterans budget for fiscal year 2002. On behalf of America's veterans, we thank the Committee on the Budget for considering our recommendations.

Sincerely,

Christopher H. Smith,
Chairman

Lane Evans,
Ranking Democratic Member

BACKGROUND AND COMMITTEE RECOMMENDATIONS

In a number of areas summarized below, the Members of the Committee are convinced more must be done and can be done in a responsible, accountable manner to reaffirm our Nation's commitment to veterans. The Committee strongly recommends the addition of funding needed to improve areas affecting the delivery of services, particularly to service-connected and low-income veterans.

DEPARTMENT OF VETERANS AFFAIRS

VETERANS HEALTH ADMINISTRATION

Medical Care

Inflation.—Health care inflation in the United States was reported to be 4.3 percent in 2000, and some experts predict higher rates this year. This is about 1 percent above the general inflation rate in the U.S. economy. Inflation poses significant challenges to the Department of Veterans Affairs. One reflection of this, for example, is that the increase in insurance and managed care premiums paid by enrollees of the Federal Employee Health Benefits Program averaged nearly 10 percent from 2000 to 2001. This "corporate" inflation alone represents almost $40 million in outlays. VA health care employees deserve a significant pay raise in 2002. The comparability rate increase for all federal employees is expected to be 3.5 percent. If so, VA's contribution to employees' pay raises would be about $425 million. Also, energy costs are expected to significantly inflate costs in energy-intensive industries and businesses this year. VA Medical Centers, employing 180,000 staff and caring for 3.9 million veterans in over 600 sites, are significant consumers of federally procured energy in gas, oil, electricity, steam, nuclear materials, etc. Unquestionably these costs will rise, but will not produce higher productivity or efficiency in VA's "business" of providing quality care to the Nation's veterans.

A simple inflation rate of 4.3 percent in VA health care would mean, conservatively, that about $900 million of any increase in funding VA health care from fiscal year 2000 would be consumed simply by the general erosion of purchasing power it will experience from a variety of external forces. The Committee believes that the budget approved by Congress must overcome inflationary pressures beyond the inflation rate itself, in order to assure that veterans' earned rights to VA health care will not be undermined by external factors over which the VA Secretary has virtually no control. Therefore, the Committee recommends for the VA health care account $1 billion over the fiscal year 2001 appropriated level for uncontrollable cost increases.

Millennium Act Implementation.—In 1999, Congress enacted the Veterans Millennium Health and Benefits Act (Public Law 106–

117). This legislation authorized the Secretary of Veterans Affairs to reimburse veterans costs of non-VA emergency care provided they are enrolled in the Veterans Health Administration and lack health insurance. When fully implemented, VA estimates this provision will cost between $400–$500 million annually. Since the law's effective date (May 2000), VA Headquarters has collected claims for reimbursement from its medical centers totaling $21 million. As more veterans learn they may be eligible for this new benefit, the Committee expects the number of claims to grow.

A number of additional provisions in the Millennium Act still require implementation. VA and the Administration are still developing and reviewing regulations that will clarify the broad guidance Headquarters has already provided to medical centers about implementation of the bill. Until regulations are completed, however, the Committee expects that full implementation will lag. Assuming that regulations become available early in fiscal year 2002, the Committee expects VA will begin a gradual implementation of its non-VA emergency care reimbursement program as well as other major provisions of the bill. The Committee recommends that an additional $68 million be provided for Millennium Act implementation in FY 2002.

Mental Health Programs for Disabled Veterans.—Over the past five years, the Department has conducted a managed shift of resources and programs away from institutional mental health care. The Committee supported this reallocation (see House Committee Print No. 5, 106th Congress, First Session, March 16, 1999). However, it was understood at the time that sufficient resources would be preserved to provide an appropriate level of care for VA's chronically mentally ill patients. VA designed new community-based intensive case management programs. In fact, these plans only partially materialized while VA shifted critical resources away from mental health.

The VA Advisory Committee on Seriously Mentally Ill Veterans estimates the diversion of funds may be as much as $600 million. VA dramatically expanded its primary care clinics, referred to as "Community Based Outpatient Clinics" (CBOCs). While the Committee certainly supports the primary care clinics, VA also should at least partially restore lost support for these mentally ill veterans, an especially vulnerable group. The budget requested could not do this. To release these veterans to the community and then provide occasional clinic visits in a primary care setting is not optimal care for the severely mentally ill. The VA Program Evaluation Resource Center maintains a registry of veterans suffering with psychosis and bipolar disorder that contains 200,000 individuals. These veterans cannot be sustained medically without intensive attention, and because of the nature of their illnesses, most cannot speak for themselves. To this end, the Committee recommends a number of adjustments to redress their unmet needs in the following areas:

1. Mental health intensive case management teams

The Committee understands that VA presently operates about 50 intensive case management teams assigned to intensive aftercare of VA patients with serious and chronic mental

illness. Some of these teams that already had a minimal staffing complement have recently suffered reductions in staff. A fully functioning team's annual average direct cost (primarily in staffing) is approximately $400,000. If VA were to deploy 30 additional teams during the 2002 budget year and restore resources to those existing teams that have been reduced, these 80 fully functioning Mental Health Intensive Care Management teams could, for an estimated cost of $40 million, provide vulnerable veterans better follow-up care and improved coordination of community based services, including foster care, sponsorship, lifestyle and medication monitoring, employment and training options; and a higher quality of life.

2. Mental health in community primary care

The Department operates approximately 350 community based outpatient clinics, distributed nationwide. When VA made the decision to provide better access to community-based primary care, it did not sufficiently provide for mental health needs in these clinics. Approximately 40 percent of these facilities offer dedicated mental health services but the remaining 200 sites do not. The addition of qualified mental health staff to support effective professional services in these settings, given the depletion of mental health resources in VA medical centers, is a way to ensure that mental health care becomes more accessible and convenient. A clinic with an average workload may require a part-time mental health practitioner, a full-time social worker, and a part-time clerk. Adding a small cadre of mental health professionals in each of the approximately 200 locations, according to their need, would provide a more complete service in VA community-based clinics. A $40 million enhancement to mental health capacity would also give VA better options to treat/provide care to not only the de-institutionalized chronically mentally ill, but also veterans with acute mental health needs who may not otherwise receive adequate care.

3. Substance-use disorder programs

VA currently cares for 130,000 veterans with this troubling and life-long disorder. Over the past decade, VA shifted its drug treatment programs from residential care to ambulatory-based programs. VA has acknowledged in its report required by Public Law 104–262 on special program capacities that capacity in the substance-use disorder programs is declining. The Committee believes these programs should be restored, along with enhancements in VA's opioid-substitution programs using Methadone and newer substitutes. These activities are insufficiently available in VA facilities and, in some metropolitan areas, do not provide enough care to meet the veteran population's needs. The Committee believes that the reduction in resources combined with the inadequate availability of these clinics could be addressed with $40 million in additional funds.

4. Increased psycho-pharmaceutical costs

In the past 10 years, a number of new antidepressants, antipsychotics and other pharmacological treatments in mental health have emerged that cause inflationary spikes in VA's

overall pharmaceutical budget. Currently, 17 percent of VA's total pharmacy budget is spent on psychotropic drugs; nevertheless, the Serious Mental Illness Treatment, Research and Evaluation Center has reported widespread variability in the use of some of the most effective drug therapies, particularly atypical drugs such as Clozapine for the management of schizophrenia. The Committee believes that additional funding of $20 million should be dedicated to these agents to ensure that VA makes available to veterans the latest therapeutic agents.

5. Evaluation in mental health programs

The Department evaluates and monitors its mental health programs in three small analytic centers, the Northeast Program Evaluation Center, located at the VA Medical Center, West Haven, Connecticut, the Program Evaluation Resource Center at the Palo Alto VA Medical Center in Palo Alto, California, and the Serious Mental Illness Treatment Research and Evaluation Center at the VA Medical Center in Ann Arbor, Michigan. Each of these research-oriented activities has aided the Department, the VA Advisory Committee on Seriously Mentally Ill Veterans, mental health advocates and the Congress in assessing the effectiveness of VA's mental health, substance-use disorder and homelessness programs. The Committee recommends a small but crucial additional allowance of $1 million be provided to these centers for continuation of their vital work in evaluating and reporting on VA's mental health mission.

VA Long-Term Care and Diseases of Aging

Demand for Services.—The Veterans Millennium Health Care and Benefits Act of 1999 clarified and expanded VA's mission to maintain specialized capacity to care for aging veterans. The Committee in crafting the Millennium legislation challenged VA to reposition itself to meet the needs of the World War II veteran generation, now averaging 80 years of age. Many of these veterans suffer from a multiplicity of age-related problems and diseases. Of particular note and concern to the Committee are Alzheimer's Disease, other dementias and other brain disorders. About 600,000 veterans are estimated to be suffering from brain diseases, most of who live at home with family caregivers. Indeed the Department is attempting to address some of their specialized needs, but the Committee noted that the shift to primary care has had an erosive effect on VA's distinguished mental health programs. This decline also detracts from VA's ability to mount and sustain programs to deal with veterans' problems associated with advanced age. While VA reports it is operating some small-scale delivery models and pilot programs to meet these challenges in geriatric care, the Committee believes VA's efforts to date only begin to address the potential demand for services. Specific recommendations are as follows:

1. Dementia special care (inpatient) units

At the Bedford, Massachusetts VA Medical Center, VA operates a Geriatric Research, Education and Clinical Center (GRECC), one of 21 such centers of excellence in geriatrics.

The Bedford Center has developed an innovative approach to caring for veterans with Alzheimer's Disease and other dementias that should be exported to other VA medical centers. The Committee recommends $55 million for advancing the concept developed at the Bedford center to all VA networks to place VA health care in the forefront of treatment for persons with Alzheimer's Disease and other brain disorders. Also, placing one such unit in each of VA's 22 networks of care provides a more equitable distribution of public resources of a specialized program that all veterans should be afforded.

2. Dementia and end-of-life care in home-based and VA nursing home care

VA sponsors home-based primary care programs in about 75 sites. Also the Department operates 131 VA nursing home care units. The Committee believes many of these programs are unable to fully address needs for dementia or end-of-life care because of resource constraints. Whether under care at home or in VA's nursing homes, veterans with Alzheimer's Disease and other forms of dementia require specialized services. VA has identified an approach that adds a focused complement of these services to its HBPC/NHCU programs. The Committee supports VA's "rapid cycle improvement" in this area and encourages its implementation. An initial increment toward this goal can be attained with a modest funding increase for HBPC programs of $17 million ($3.5 million in HBPC; $13.5 million in NHCU).

3. Psycho-geriatric evaluation and treatment

Nine VA medical centers currently operate "Unified Psychogeriatric Biopsychosocial Evaluation and Treatment" or "UPBEAT" programs. These programs test the hypothesis that intensive psychosocial intervention in cases of hospitalized elderly veterans with depression, anxiety or substance-use disorders can reduce the number of days veterans require hospitalization. The model is proving successful, and VA is poised to expand the application with additional resources. Operational UPBEAT programs are cost effective and result in better care for veterans. Adding 15 additional sites in VA medical centers will give more veterans access to these programs at reasonable cost of $6 million.

4. Dementia caregiver respite program

The majority of veterans with Alzheimer's Disease and other dementias receive their care at home from family caregivers. Given their responsibility for providing around-the-clock care, these caregivers need periodic relief from their care duties. VA has a small, ongoing program of respite care. A substantial expansion is essential, but is not addressed in current agency plans. The Committee proposes an expansion of VA's caregiver training program accompanied by provision of a period of respite care to allow veterans' caregivers relief from their duties for 2–4 weeks each year. This expansion would allow VA to provide such care in 12 additional locations, at a total estimated cost of $10 million.

Unacceptable Waiting Times for Outpatient Care.—The extraordinary growth of demand for care is resulting in thousands of veterans being denied access to care in VA facilities. Once VA accepts veterans for enrollment, it must ensure that it has adequate resources to provide reasonable access to the full range of services that it has committed to offer enrolled veterans. VA has described access in terms of geographic proximity, reasonable patient costs, and the ability to meet a reasonable (community) timeliness standard. While VA has accomplished its goal for geographic access and veterans' copayments are reasonable, its progress in accomplishing, and even its ability to assess timeliness is problematic. (See Veterans Health Care: VA Needs Better Data on Extent and Causes of Waiting Times, May 20, 2000, GAO/HEHS–00–90.)

At the VA Chicago Medical Center, veterans wait up to 214 days to be seen in the gastroenterology clinic. This delay is attributed to higher demand from veterans suffering from hepatitis C. In New Jersey's Brick and Ft. Dix VA community-based clinics, veterans are required to wait to be seen by a VA practitioner from 6 to 11 months for an initial, non-urgent appointment. The Department created high expectations within the veteran population, many members of whom had never used VA health care before, as it expanded services away from VA medical centers to communities for improved access and convenience nearer veterans' homes. Veterans had a reasonable expectation to be able to use these services routinely once these clinics were fully functioning, as well as to begin, or continue, using VA medical centers when appropriate. As of today, however, their access to care in many cases is being rationed by strict resource limitations.

The Committee believes that Congress should take the lead and respond now to these veterans' needs. Therefore, the VA Committee recommends additional funds in the amount of $75 million be provided in the fiscal year 2002 budget to supplement VA's allocation of resources to both VA medical centers and their community-based outpatient clinics. The new funds will support the employment of 1,000–1,500 new Veterans Health Administration staff, to increase practitioner presence in VA's 350 community-based clinics and supplement ambulatory care staff in VA centers. The Committee believes this is a modest method to address a very challenging situation in VA health care.

Rising Pharmaceutical Costs.—The VA expects to expend about $2.7 billion this year on pharmaceuticals. VA's budget for prescription drugs has doubled over the past 5 years and, at the current rate of growth, will exceed $4 billion in only 3–4 more years. Higher VA drug costs at the present time are not due to inflation; pharmaceutical cost increases as an element in overall health care inflation are abating. VA's higher costs stem from utilization and the advent of new drugs. As of December 31, 2000, the Veterans Health Administration reports that 4.7 million veterans are enrolled in VA health care, and nearly 3.9 million are expected to be active consumers of VA health care services this year. If the higher enrollment is overlaid on the phenomenon of veterans' aging, about which so much has already been reported, along with new pharmaceutical therapies being made available, it becomes clear that VA's success in reaching more veterans to meet more of their health

care needs is going to produce extraordinary pressure on VA's pharmaceutical budget. The Committee is particularly concerned about veterans' access to the apparently uneven availability of drug treatment for Hepatitis C and psychotropic agents (see below). The Committee believes that, beyond funding VA adequately to cover its inflationary challenges so that VA will be able to meet the growing disease burden among the veterans treated in VA facilities, Congress should provide supplemental funding to assist VA providers in ensuring that adequate pharmaceutical resources are made available to support their professional prescribing. Therefore, the Committee recommends an additional $100 million above normal inflation for fiscal year 2002 to ensure that VA resources are sufficient to meet these pharmaceutical demands.

Specialized Programs–Restoration of Spinal Cord Injury Care

The Veterans Health Care Eligibility Reform Act of 1996 requires VA to maintain the capacity of specialized programs for certain disabled veterans, including those with spinal cord injury or dysfunction. VA has identified beds, full-time employees, dollars, and patients treated as measures that best depict VA's maintenance of capacity for this program. VA now acknowledges a 65 percent reduction in its specialized bed capacity for veterans with spinal cord injury or dysfunction. The Committee is very concerned about this unacceptable reduction in services for one of VA's most physically challenged patient populations.

To restore and enhance care in this area, VA developed a plan in concert with Paralyzed Veterans of America. VA's Under Secretary for Health issued a formal directive to establish a minimal level of staffing and staffed beds at each of 23 medical centers with a spinal cord injury center and also issued a memorandum to managers to identify the resources necessary to restore staff to a minimum level of capacity. VA agrees that there are more than 200 staff vacancies in its SCI program. Most of these vacant positions are nurses, but therapists, psychologists and physicians are also in short supply. While the plan fulfills needs for long-term care, the Committee's proposal only restores acute care capacity. Paralyzed Veterans of America estimates restoring only acute care capacity will require $23 million. The Committee supports $23 million to fund this restoration of capacity.

Homelessness among Veterans

The Committee remains dedicated to addressing homelessness in the veteran population. The Committee is encouraged by recent data showing that, since 1987, there seems to be a perceptible, if small, reduction in homelessness among veterans, estimated to be 8.5 percent. Nevertheless, according to VA's most recent estimates, about a quarter-million veterans are still homeless in this country at some point each year.

Over the past 15 years, the Committee has developed legislation that authorized, expanded and extended VA's programs addressing homelessness. Among these are in-house homeless domiciliary expansion, a grant and per diem program for community providers, and the so-called "Health Care for Homeless Vets" initiative. VA

also funds several smaller programs in mental health and coordinates with other Federal agencies (principally the Departments of Housing and Urban Development, and Labor) to address veterans' homelessness. The Committee recommends $30 million additional funding for these programs, including funds to increase the grant and per diem program and enhance existing and add new VA Domiciliary Care for Homeless Veterans programs during fiscal year 2002.

Medical and Prosthetics Research

The Department carries out an extensive array of research as a complement to its health-professions affiliations. While these programs are specifically targeted to the needs of veterans, VA research discoveries help define new medical standards of care that benefit all Americans. Among the major emphases of the program are research into aging, chronic diseases, mental illnesses, substance-use disorders, sensory losses, and trauma-related illnesses. VA's research programs are internationally recognized and have made important contributions in virtually every area of medicine and health for veterans and the general public. These contributions to medical knowledge have won VA scientists many prestigious awards, including six Lasker Awards and three Nobel Prizes in Medicine.

Advances by VA researchers in the past two years include findings from several major clinical trials of significant potential value and relevance. These include research in cancer, heart disease, anemia and kidney failure. Important new VA studies are underway now in post-traumatic stress disorder in women veterans; amyotrophic lateral sclerosis ("Lou Gehrig's Disease"), fatigue, muscle and joint pain, and memory and cognitive problems among Persian Gulf War veterans; and the development of a vaccine for shingles.

The Committee supports an increase in the research account of $30 million. We believe this additional funding is needed in VA's research programs to keep pace with external funding developments in the U.S. biomedical research field. We note the President's State of the Union address confirmed the national goal to double the research funding of the National Institutes of Health. Additional funding of $30 million in VA biomedical research in fiscal year 2002 would cover inflation and permit a small program expansion.

Medical Administration and Miscellaneous Operating Expenses

The Medical Administration account supports the employment of 535 Central Office staff and officials to oversee and manage the multiplicity of programs that deliver health care to America's veterans.

The Committee is concerned that the Medical Administration and Miscellaneous Operating Expenses (MAMOE) account may not provide a sufficient resource base to ensure high-quality patient care services while VA simultaneously continues to restructure its health care delivery system. In particular, the Committee has pressed VA to improve its methods of assuring accountability, be-

ginning with the Under Secretary for Health, and extending to the Administration's 22 network directors, who operate in a highly decentralized management environment. MAMOE requires additional staff and resources to properly carry out the responsibilities of supervising, managing, and accounting for the diverse and far-flung health care system.

A modest increase of $5 million in this MAMOE account would provide the VA Central Office a funded staff of 589 in fiscal year 2002 to better manage its essential health care programs.

Medical Facility Construction

Urgently Needed Projects.—VA is now undertaking an initiative to identify the most effective and efficient use of its infrastructure in care delivery to veterans. The VA uses the acronym "CARES" (for Capital Assets Realignment for Enhanced Services) to describe this initiative. The Committee held a number of hearings during the 106th Congress dealing with VA's capital assets. VA hospitals were primarily built or converted after World War II to rehabilitate and care for wounded, sick and traumatized soldiers, sailors, airmen and marines. The Committee agrees with the principle that VA should seek the most effective use of its facilities and modernize, or declare as excess, buildings based on the health care needs of veterans.

In the wake of its wars, the nation faced the daunting task of dealing with hundreds of thousands of wounded and maimed veterans. The care VA provided to the most seriously injured of these veterans often concluded years, rather than days or even months after a patient's initial admission. VA has now changed its approach to care from that of being an institutional provider of rehabilitation and restorative care to that of largely being a primary care provider often serving and older population. The capital infrastructure built for its previous approach does not easily lend itself to its new delivery model.

Even though VA's CARES process is ongoing, the Committee believes that VA's most pressing capital infrastructure needs must to be addressed. In recent years, VA has proposed few construction projects, and, awaiting the outcome of the CARES process, Congress appropriated little funding for this purpose the last four years.

Outside consultants and VA's own reports show a growing need and rising backlog of major and minor projects. For example, a 1998 Price Waterhouse report suggested VA, in proportion to the value of its $35 billion infrastructure, should be investing in the range of $700 million to $1.4 billion annually on replacement and modernization projects. A second consultant report disclosed dozens of VA patient care buildings at the highest level of risk for earthquake damage or even collapse. Indeed, a 6.8 tremor on February 28, 2001, damaged two of VA's patient care buildings at the American Lake VA Medical Center cited by this consultant. Another report revealed $57 million in needed projects to protect women's privacy in VA health facilities.

The Committee believes that, regardless of the course the CARES process identifies for VA's infrastructure, continuing main-

tenance on the system is essential to keep it viable and safe. To this end, on March 1, 2001, the Chairman and a number of other Committee Members introduced H.R. 811, the Veterans' Hospitals Emergency Repair Act, to authorize the Secretary to select small to medium-sized projects to maintain and improve VA facilities while CARES proceeds. The bill would authorize $250 million in capital projects in fiscal year 2002, subject to the Secretary's site selection based on specific criteria in the legislation. The Committee believes that these funds are critically needed and recommends $250 million be provided for this interim program for fiscal year 2002.

Major Construction Projects.—Since fiscal year 1996, under the authority of section 8104 of title 38, United States Code, Congress has authorized nearly $1 billion for 41 major medical facility projects. However, due to lack of specific appropriation, only 28 of these projects were completed. Authorizations for these projects for this year alone total over $100 million, but no appropriations were provided. The Committee believes that funding should be provided for Congressionally authorized major medical facility projects. Therefore the Committee recommends that $112 million be provided to fund at least some of these previously approved facilities.

Minor Construction Projects.—For many of the reasons we stated above with respect to the delegated-projects proposal the Chairman and colleagues recently introduced, the Committee believes that VA needs to increase its investment in the minor construction program. VA hospitals, nursing homes and other health care facilities are deteriorating, and not enough is being done about it. Therefore, the Committee recommends that the minor projects account—an activity that funds hundreds of very inexpensive yet critical maintenance and repair needs—be provided $200 million in fiscal year 2002 to address some of the large backlog presently awaiting funding.

State Home Grants Programs

The Department has not approved requests totaling $245 million for new construction and renovation grants for state veterans homes and other facilities. A new round of requests under this program will soon be solicited for fiscal year 2002. This program is the only one of three available types of institutional long-term care that is expanding to meet the needs of the aging veteran population. Moreover, states commit to pay 35 percent of the construction costs for these facilities and to bear most of the cost of care that exceeds amounts contributed by the VA (current daily VA reimbursements are $51 for nursing home care and $22 for domiciliary care for each veteran).

Congress revised the state home program in Public Law 106–117 to provide a higher priority for renovation needs in existing state homes. Until enactment of P.L. 106–117, these longstanding projects were given a lower priority for funding than grants for constructing new beds. Given the recent changes in law and the growing backlog of unfunded projects, the Committee proposes additional funding of $35 million to support a more adequate VA response to this ever-growing demand for long-term care facilities.

VETERANS BENEFITS ADMINISTRATION

General Operating Expenses

The General Operating Expenses account funds full-time employee equivalents (FTEE) and operating expenses for both the Veterans Benefits Administration (VBA) and VA's Central Office (headquarters). VBA administers a broad range of non-medical benefits to veterans, their dependents, and survivors through 58 regional offices. These programs include compensation and pension, education, vocational rehabilitation, insurance, and loan guaranty (home loans). VBA is also responsible for processing applications for these programs. Headquarters includes the Secretary's staff and other VA support staff, and is located in Washington, DC.

The Committee supports a funding increase of $49.8 million for 830 additional FTEE for compensation and pension claims adjudication. VBA has a backlog of more than 459,000 claims waiting to be processed. During the three-month period of November 24, 2000 to February 23, 2001, the backlog of pending claims increased by 130,294, from 329,278 to 459,572. This is an average weekly increase of more than 10,000 pending claims. Adverse effects of the increasing backlog are a decline in the quality of work, veteran satisfaction and employee morale. Approximately one-third of claims decisions have some type of error, most of which are administrative in nature. However, 4.2 percent of errors do involve grant/denial or rating issues. The percent of cases remanded from the Board of Veterans' Appeals has declined from 45 percent in 1997 to about 29 percent today, thus reducing the number of claims that must be reworked by the regional offices. However, there has been an increase from 16 percent to 26 percent in the number of claims denied by the regional offices that have been allowed by the Board. In fiscal year 2000, only 41 percent of the decisions appealed from regional offices were upheld by the Board of Veterans' Appeals.

The Committee commends the Department for numerous initiatives including:

- Pre-Discharge compensation examinations and ratings (including overseas);
- Case management;
- Decision Review Officer program;
- Establishment of nine Service Delivery Networks;
- Systematic Technical Accuracy Review program;
- Data integrity initiatives;
- Electronic claims filing including online benefit applications;
- Development of paperless claims folders known as "Highway One;"
- Reader-focused writing; and
- The "Balanced Scorecard."

Despite these numerous initiatives by VBA, it still takes 205 days to adjudicate an original compensation claim. It is important to understand the customer base in VA's $21 billion per year compensation and pension program. According to the 1996 report of the Veterans' Claims Adjudication Commission, if VA stopped receiving first-time disability claims in 1995 for a period of 20 years, and repeat claims activity remained consistent with current levels over

that time, in the year 2015 VA would still have 72 percent of the 1995 workload—without taking a single new claim. The majority of VA claims for disability compensation are on the lower end of the rating schedule. Claims rated below 30 percent generate a large number of the reopened claims and appeals. The VBA Annual Benefits Report for Fiscal Year 1998 notes that most disabilities are rated at 30 percent or less, including 94 percent of the 95,000 veterans added to VA compensation rolls in fiscal year 1998. The VBA Annual Benefits Report for Fiscal Year 1999 found that 57 percent of disability compensation payments are less than $200 monthly.

Another dimension of the current system as designed by Congress is the percentage of veterans who file for claims and are already receiving VA compensation. Such "reopened" claims outnumber original claims almost 3 to 1. The Congressional Veterans' Claims Adjudication Commission found that veterans already in receipt of compensation file 69 percent of reopened claims and 67 percent of appeals. Veterans may reopen a claim because a service-connected condition has worsened or they have obtained new and material evidence concerning a decision or evaluation on a previously adjudicated claim. A recent survey by the Veterans Benefits Administration found that the average age of a veteran filing an original claim is 34, the average life expectancy is 77, and the average number of claims expected in a lifetime is 17.9. The average age of veterans receiving service-connected compensation benefits is 59 with 26 percent of service-connected veterans between the ages of 50 and 59. The medical conditions most frequently service-connected involve orthopedic conditions and hearing loss, conditions which can be expected to worsen as veterans age. Thus, it should be anticipated that VBA would see an increase in veterans reopening their claims as their service-connected conditions worsen during the aging process.

Veterans rarely file for only one disability. With respect to new claims, in fiscal year 1999, the average number of disabilities filed per claim was 4.72. The average number of service-connected disabilities granted to Gulf War veterans is more than 80 percent greater than for World War II veterans. From 1979 to 1999, the number of disabilities for which VA pays service-connected benefits increased from 3.0 million to 5.7 million, while the number of veterans receiving service-connected compensation increased from 2.1 million to 2.3 million. Gulf War and peacetime veterans file for and receive compensation at a higher rate than Vietnam, Korea, and World War II veterans.

Benefit Program Operations

Compensation & Pension Service (C&P).—The ability of VA to furnish timely and quality benefits delivery is heavily dependent on a combination of proper staffing levels, effective implementation of computer modernization initiatives, training and retention incentives, and inter-departmental cooperation between various VA organizations and the military service branches. Over the decade of the 1990's, the number of trained personnel in the adjudication division declined by approximately 40 percent.

According to the President's Blueprint for New Beginnings, the budget fully implements new legislation that strengthens VA's "duty to assist" veterans in preparing their claims and a regulation that adds Type 2 diabetes to the list of presumptive conditions that are associated with exposure to herbicides. The President's budget asserts that it fully funds the VBA additional workload for this initiative and assumes that VBA will develop a vision for future benefits delivery that incorporates and harnesses paperless technology. Part of this effort to modernize will be for VBA to complete the consolidation of aging data centers into its state of the art facility in Austin, Texas.

However, with respect to anticipated workload under "duty to assist" requirements, the Committee understands that for the current fiscal year VA will need to rework about 98,000 claims previously denied under the *Morton* v. *West* decision, 12 Vet. App. 477 (1999), review the current inventory of 342,000 claims for compliance with duty to assist requirements and take corrective actions, and perform expanded development on 87,000 new claims. VBA expects to receive 105,000 new claims for service connection of Vietnam veterans who have been diagnosed with Type 2 diabetes. VA's average age of pending claims is expected to climb to 241 days by the beginning of fiscal year 2002 from VA's target of 119 days.

VA must have additional personnel to make up for past reductions in claims adjudicators, to meet increased workload demands, to provide essential training for current and new personnel, to ensure quality, and to achieve and maintain satisfactory timeless in claims processing. Approximately 40 percent of VBA's workforce is in training status.

If VA's claims' adjudication system does not have quality, it does not serve veterans. To improve quality, VA should devote more resources to training. To deliver training on a system-wide basis, VA will need to add 200 FTEE in fiscal year 2002. To meet the projected workload demands, VA should add 170 new adjudicators. To handle its appellate workload in regional offices, VA needs 200 additional Decision Review Officers, a concept recommended by the Veterans' Claims Adjudication Commission. Regional offices that have implemented the DRO program have seen a significant decline in the number of claims that are appealed to the Board of Veterans' Appeals.

VA also would benefit from staff to conduct quality reviews of the work of each of its claims adjudicators to assess performance, impose accountability, and remedy deficiencies on an individual level. Through its Systematic Individual Performance Assessment initiative, VA intends to review 100 decisions from each adjudicator per year. VA would need about 260 new employees in fiscal year 2002 to accomplish this task.

In summary, for the above initiatives, the Committee recommends a total of 830 FTEE at a cost of $49.8 million. Also, the Committee expects a continuing adverse affect in services in the absence of an urgently needed supplemental appropriation for fiscal year 2001 of about $26.6 million (347 FTEE) for compensation and pension claims processing. Absent funding of a supplemental appropriation for fiscal year 2001, the Committee anticipates that additional funding will be needed in fiscal year 2002.

Vocational Rehabilitation and Employment Program (VR&E).—The goal of the Vocational Rehabilitation and Employment program is employment of disabled veterans and eligible dependents. To accomplish that goal, VR&E is authorized to furnish all services and assistance necessary to enable service-connected disabled veterans to become employable, obtain and maintain suitable employment, or to achieve maximum independence in daily living. Additionally, VR&E is authorized to provide educational and vocational counseling services to eligible active-duty members, veterans and dependents.

VR&E was recently renamed to reflect a newfound emphasis on employment—the program's ultimate goal. The Committee has been pleased with recent VBA initiatives to promote better case management and lifecycle completion times and success rates. The Committee is also pleased thus far with VR&E's progress with implementing Employment Service Specialist positions into existing service delivery schemes. Further, the Committee commends the VR&E program for its strategic document "The Business Case Continues."

The Committee remains concerned, however, with VR&E's relying too heavily on private contractors to fulfill various phases of the VR&E program lifecycle. Further, participant dropout rates and the quality of post-program employment are still troubling to the Committee. Therefore, the Committee recommends a $2 million increase above the fiscal year 2001 funding level.

Educational Assistance Programs.—VA's Education Service administers the All-Volunteer Force Educational Assistance Program (Montgomery GI Bill, chapter 30), the Post-Vietnam era Veterans' Educational Assistance Program (chapter 32), the Vietnam era Veterans' Educational Assistance Program (chapter 34), the Survivors' and Dependents' Educational Assistance Program (chapter 35), and numerous other activities, including overseeing the role of State Approving Agencies and coordination with the Department of Defense on the Selected Reserve aspect of the Montgomery GI Bill. Public Law 106–398 and Public Law 106–419 expand opportunities for increased usage of the educational assistance programs administered by VA. Several provisions will provide significant workload challenges for VA.

First, the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001 (P.L. 106–398) gives members of the Armed Forces an opportunity to receive increased payment for off-duty education and training. In most cases, the service branches can pay up to 75 percent of the tuition or expenses for off-duty education. Under the new law, the military services can pay up to 100 percent of tuition and expenses charged by the school. If the service branch pays less than 100 percent, a servicemember eligible for the MGIB can elect to receive MGIB benefits for all or part of the remaining expenses. VA administers this program, though most of the costs are borne by the service branch. VA anticipates about 161,000 new claimants in this program in fiscal year 2001 and 214,000 additional claimants in fiscal year 2002. In fiscal year 2002, if the military services maintain a 75 percent Tuition Assistance reimbursement policy and all servicemembers seek payment of the balance

from VA, VA's workload could double, thus requiring 151 additional FTEE for 340,000 additional claims annually.

Second, the Veterans Benefits and Health Care Improvement Act for 2000 (Public Law 106–419) allows payments for licensing and certification tests under the chapter 30, 32, and 35 programs. These tests are needed to enter, maintain, or advance into employment in a civilian vocation or profession. The eligible veteran or family member receives reimbursement for the fee charged for the test, or $2,000, whichever is less. VA estimates 100,000 veterans will apply for such benefits in fiscal year 2002 and will need 65 additional FTEE for this purpose.

Third, Public Law 106–419 also creates an opportunity for some 139,000 active duty servicemembers who have zero dollars in their Post-Vietnam Era Veterans' Educational Assistance Program (VEAP) account or have dollars in their account and did not act on a previous opportunity to convert to the Montgomery GI Bill to do so. These servicemembers can become eligible for MGIB if they 1) make an irrevocable election to receive MGIB, 2) were VEAP participants on or before October 9, 1996, continuously served on active duty from October 9, 1996 through April 1, 2000, and 3) make a payment of $2,700. VA estimates 13,000 individuals will convert to MGIB in fiscal year 2002 requiring 8 FTEE.

Last, the Committee notes degradation in education claims processing due to the transfer of all education inquiries (about three million calls annually) from 58 regional offices to four regional processing offices without additional FTEE, and the transfer of about 50 FTEE in fiscal year 1999 and 45 FTEE in fiscal year 2000 to the Compensation and Pension Program. Not surprisingly, the four regional processing offices currently have a pending workload of about 90,000 education claims for which veteran-students are awaiting payment, far exceeding acceptable levels set by VBA. While the Committee appreciates the need to furnish more FTEE to the compensation program, the 95 FTEE transferred from education claims processing to Compensation and Pension processing represents a significant percentage of the approximately 800 FTEE used to process education claims. The Committee recommends 95 additional FTEE for education claims processing to fill this void.

In summary, the Committee recommends an additional 329 FTEE at a cost of $13.16 million for education claims processing. Further, the Committee notes a demonstrable adverse affect in services in the absence of an urgently needed supplemental appropriation for fiscal year 2001 of about $2.5 million (60 FTEE) for education claims processing.

State Cemetery Grants Program.—The State Cemetery Grants Program provides grants to assist the states in establishing, expanding, and improving state-owned veterans cemeteries. Increasing the availability of state veterans' cemeteries is one way to serve veterans who do not reside near a national cemetery. State cemeteries augment—but do not supplant in any way—VA's national cemetery program. VA has awarded 106 grants totaling more than $87 million to establish, expand, or improve 49 veterans cemeteries in 26 states plus Guam and Saipan. Forty-three cemeteries in 22 states and Guam are now operational. The Committee recommends

an increase from $25 million in fiscal year 2001 to $30 million in fiscal year 2002.

NATIONAL CEMETERY ADMINISTRATION

The National Cemetery Administration (NCA) provides national shrines honoring those who served in uniform and should be maintained as places of high honor, dignity and respect. Currently, NCA maintains more than 2.3 million gravesites in 119 national cemeteries in 39 states (including Puerto Rico), as well as 33 soldier's lots and monument sites. The Committee recommends a $25 million increase over fiscal year 2001 funding for the beautification, upkeep, maintenance and repair of the national cemetery system.

Since 1973, when NCA was established, annual interments in national cemeteries have more than doubled from 36,400 to more than 82,700. NCA provided more than 327,000 headstones and markers in fiscal year 2000 compared to 190,000 headstones and markers in 1973.

It is estimated that 574,000 veterans died in 2000, and veterans' deaths are expected to peak at 620,000 in 2008. To meet the increasing workload, section 611 of Public Law 106–117 directed the Secretary of Veterans Affairs to establish six additional national cemeteries in those areas the Secretary deems to be most in need.

In response to the growing demand for burials in national cemeteries, section 613 of Public Law 106–117 required the Secretary to conduct an independent study on improvements to veterans' cemeteries. The study will include an assessment of the one-time repairs required at each national cemetery under the jurisdiction of the NCA to ensure a dignified and respectful setting appropriate to such cemetery, and shall identify: 1) the number of national cemeteries necessary to ensure 90 percent of America's veterans reside within 75 miles of a national or State cemetery, 2) the number and percentage of veterans in each State who would reside within 75 miles of an open national or State cemetery, 3) an estimate of the expected construction costs and the future costs of staffing, equipping, and operating the projected national cemeteries in 1) and 2) above. In addition to projecting cemetery needs at 5-year intervals beginning in 2005 and ending in 2020, the report will take into account cemeteries which will close to new burials and the age distribution of local veterans' populations during the reporting periods.

BOARD OF VETERANS' APPEALS

In fiscal year 2000, the Board of Veterans' Appeals (BVA) issued 34,028 decisions. Of those, 91 percent (30,966) involved compensation for service-connected disability. These include not only claims for service connection, but also claims for increased ratings and earlier effective dates.

The average response time for fiscal year 2000 was 220 days, down dramatically from 595 days in fiscal year 1996. At the end of fiscal year 2000, there were 20,521 cases pending before the Board, down from a high of 60,120 at the end of fiscal year 1996. BVA requires adequate funding and staffing to continue these recent improvements. The Board continues to remand a large percentage of claims to the originating regional office and has seen an

increase in the number of claims allowed by the Board after denial at the regional office level, indicating a need for more staff and better training at the local office level.

INSPECTOR GENERAL

The Inspector General is charged with ensuring that VA programs are managed efficiently and effectively and are free of fraud, waste and abuse. OIG has implemented a Combined Assessment Program (CAP) that provides on-site reviews of VA health care facilities on a cyclical basis. The CAP program is a unique joint OIG effort involving its Audit, Healthcare, Inspections and Investigations sections. The fiscal year 2002 appropriation for the OIG will support an expected 28 CAP reviews. At this pace, six years would be required to conduct a CAP review of each VA health care facility-year. An interval of six years between comprehensive CAP reviews is not in the best interest of veterans and not acceptable.

Accordingly, the Committee supports an appropriation increase for the OIG sufficient to support an additional 55 FTEE in each of the next two fiscal years. These manageable incremental increases of 55 additional FTEE in 2002 and 2003 would expand the number of CAP reviews to 56 in 2002 (43 VHA and 13 VBA) and to 76 reviews annually beginning in 2003 (57 VHA and 19 VBA).

The Committee further notes Congress established a statutory staffing floor of 417 FTEE for OIG in P.L. 100–527. Section 312 of title 38, United States Code, requires the budget transmitted to Congress for each fiscal year to be sufficient to support this statutory floor. This requirement has not been met since 1993. Current OIG staffing supported by appropriations is 369 FTEE. An additional 24 FTEE are supported by reimbursements received for Department contract review activities.

Increased staffing for the Office of the Inspector General is a prudent use of resources. Over the past three years, the monetary benefits of OIG activities have reportedly exceeded $1.7 billion, providing an average return on investment of 15 to 1. More importantly, an adequately staffed OIG will save more veterans' lives, improve the quality of health care provided, foster better access to health care, increase VA security against fraud and theft, and result in improved overall management.

The Committee recommends an appropriation of $56.5 million for the Office of the Inspector General (OIG) for fiscal year 2002. The recommended fiscal year 2002 OIG appropriation represents an increase of $8.1 million compared to the fiscal year 2001 OIG appropriation.

DEPARTMENT OF LABOR

VETERANS' EMPLOYMENT AND TRAINING SERVICE

Congress has determined that our nation has a responsibility to meet the employment and training needs of veterans. To accomplish those goals, the Assistant Secretary of Labor for Veterans' Employment and Training (ASVET) is authorized to implement training and employment programs for veterans. The ASVET also acts as the principal advisor to the Secretary of Labor with respect

to the formulation and implementation of all departmental policies and procedures that affect veterans.

The Committee is aware of the significant changes in the national labor exchange system that are *not* a part of the delivery system for veterans' employment and training services as reflected in chapter 41 of title 38, United States Code.

First, the states are changing the way they deliver employment services and adopting new service delivery models ranging from devolving state programs to the county level to privatizing some or all employment functions and instituting one-stop employment centers under the Workforce Investment Act of 1998.

Second, the current version of chapter 41 predates requirements of the Government Performance and Results Act focusing on outcomes.

Third, there is insufficient reward for states that help veterans get jobs in an exemplary manner.

The Committee remains concerned about accountability and incentives for performance in the current delivery system as designed by Congress in chapter 41. Dedicated Local Veterans Employment Representatives and Disabled Veterans Outreach Program specialists are engaging and resourceful individuals. The Committee expects to consider legislation to position them to deliver services effectively in the 21st century.

PROPOSED LEGISLATION

The President's budget submission contains a number of mandatory proposals to reduce spending in various programs through Omnibus Budget Reconciliation Act extenders. The Committee does not plan to consider these proposals.

LEGISLATION THE COMMITTEE MAY REPORT WITH DIRECT SPENDING IMPLICATIONS

Montgomery GI Bill.—The Committee recommends a three-step approach, all of which ties in with revitalizing our military. The first step was an improvement in the Montgomery GI Bill-Active Duty basic benefit from $552 to $650 per month with the enactment of Public Law 106–419 last November 1, 2000. The second or interim step will be an increase in the basic MGIB benefit in consecutive fiscal years to $800 per month on October 1, 2001, to $950 per month on October 1, 2002, to $1,100 per month on October 1, 2003, incurring a cost of about $300 million the first year and $3 billion over five years. The third and ultimate step would implement the Servicemembers and Veterans Transition Assistance Commission recommendation for an MGIB that pays tuition, fees, and a monthly subsistence allowance, thus allowing veterans to pursue enrollment in any educational institution in America limited only by their aspirations, abilities and initiative. Against the current baseline, this measure would cost about $1.3 billion in year one, and $2.6 billion over five years. The third step could be enacted in the 107th Congress if the Administration were to propose it.

The Committee cites recent data from Trends in College Pricing furnished by the College Board, and concludes that the monthly

basic MGIB benefit would need to be $1,025 per month for a veteran student to be able to pay the average tuition and expenses as a commuter student at a four-year public college for academic year 1999–2000. Over four years, the numbers are even more alarming, as reported by the College Board. The College Board's most recent statistics reflect average annual tuition and fees for attending a four-year public college is $9,229 for commuter students and $11,338 for students who live on campus. Four-year private institutions cost $21,704 and $24,946 respectively. With the current basic MGIB benefit of $5,850, however, a veteran is expected to pay for tuition, fees, and room and board over the academic year. The disparity between these ever-increasing costs and a veteran's ability to pay for them seems clear.

The MGIB now provides $650 monthly stipends over four years; the total benefit payable is $23,300. The Committee also notes the April 21, 1999, testimony of Vice Admiral P.A. Tracey, then-Deputy Assistant Secretary of Defense, Military Personnel Policy: "Since its inception, the value of the MGIB, when adjusted for inflation, has grown by only 24 percent, while college costs have risen by 49 percent."

Veterans Opportunities Act of 2001.—The Committee recommends about $60 million per year for improvements to programs of educational assistance, outreach to separating servicemembers, veterans and dependents, to increase burial benefits, to provide for family coverage under Servicemembers' Group Life Insurance, and for other purposes.

Pilot Project for Interim Assistance to Homeless Veterans.—Currently, processing of claims for compensation and pension programs takes months. The Committee notes that Representative Lane Evans plans to introduce legislation authorizing a three-year pilot program to provide three months of transitional assistance to 600 homeless veterans who are being released from institutions. The assistance may be extended for an additional six months if the veteran is awaiting a regional office decision on a claim for compensation or pension benefits. Since any transitional assistance paid would be offset from a retroactive award of compensation or pension benefits, Mr. Evans advises the Committee that the cost of this pilot program would be approximately $2 million over three years.

Homeless Veterans' Reintegration Programs (HVRP).—In section 901 of Public Law 106–117, the Committee authorized appropriations to the Department of Labor to carry out Homeless Veterans' Reintegration Projects at $10 million in fiscal year 2000, $15 million in fiscal year 2001, $20 million in fiscal year 2002, and $20 million in fiscal year 2003. The Committee notes that Representative Evans plans to introduce legislation extending HVRP and authorizing expenditures of $50 million a year in fiscal years 2002 through 2006.

Comparison of President's Proposed Budget, Independent Budget and VA Committee Recommendations for the Department of Veterans Affairs

(Budget Authority in millions)

	FY 2000 Enacted	FY 2001 Enacted	FY 2002 Admin. Request	Admin. Request +/− 2001	Indep. Budget (IB)	IB +/− FY 2001	VA Committee Recom.	VA Committee +/− 2001
Medical Care (including receipts)	$19,534	$20,890	.....	.....	[1] $22,869	+$1,979	[2] $22,415	+$1,525
Research	321	351	.....	.....	395	+44	381	+30
Construction	225	237	.....	.....	811	+583	562	+325
State Nursing Home and Cemetery Grants	115	125	.....	.....	130	+5	155	+30
Veterans Benefits Administration	858	985	.....	.....	1,071	+86	1,115	+130
National Cemetery Administration	97	110	.....	.....	119	+9	135	+25
Other Discretionary	317	336	.....	.....	467	+98	371	+35
Total VA Discretionary Including $608 million in MCCF Receipts [1]	21,467	23,033	24,033	+1,000	[1] 25,832	+2,799	25,134	+2,101
VA Mandatory Spending	23,397	24,586	28,100	+3,514	...	...	28,400	+3,814

[1] The Independent Budget (IB) advocates that all funding for medical care be provided through appropriations. Therefore the IB Medical Care and Total VA Discretionary amounts *do not* include MCCF receipts.

[2] The VA Committee Recommendation assumes that the one-time change to the law regarding "Millennium Bill" receipts contained in the VA's appropriation bill (P.L. 106–377) will not be extended past fiscal year 2001. Thus, individual facility budgets will be augmented to the extent VA actually implements this collection authority.